

**KENT CITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION**

This form is the school's only way of arranging emergency treatment for your child. Please help us help your child by filling out completely and legibly. Please contact the school immediately if any of the information is changed.

Child's Name _____	School D F H L W SMS RHS Grade _____
Address _____	Mother's Name _____
_____	Father's Name _____
Home Telephone Number _____	Date of Birth _____
Email Address(es) _____	_____
Child resides with (circle all that apply): Mother Father Stepmother Stepfather Grandparent Guardian Other _____	
Medical History:	Date of Last Tetanus _____
Facts concerning child's medical history, including allergies, medications being taken, and any physical impairment: _____ _____	

In case of an emergency, we will contact the individuals listed below until someone is reached:				
	Adult's Name	Relationship to Child	Daytime Phone Number	Number is at:
1 st	_____	_____	_____	Home Work Cell
			_____	Home Work Cell
2 nd	_____	_____	_____	Home Work Cell
			_____	Home Work Cell
3 rd	_____	_____	_____	Home Work Cell
			_____	Home Work Cell
4 th	_____	_____	_____	Home Work Cell
			_____	Home Work Cell

PART I – CONSENT FOR TREATMENT:

In the event reasonable attempts to contact authorized persons above have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary my child's doctor(s) named below or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Phone Number: _____

Doctor _____

Other Medical Specialist _____

Dentist _____

Preferred Local Hospital _____ ER# _____

Signature of Parent/Guardian _____ Date _____

PART II – REFUSAL OF CONSENT FOR TREATMENT:

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____